

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**COMPLETE ALL SECTIONS, DATE, AND SIGN**

I, \_\_\_\_\_, hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by:	And is to be provided to:
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY Evolution Medical Associate (Phone: 727/216-3492)
ADDRESS	ADDRESS 604 Druid Road E (Fax: 727/216-3495)
CITY/STATE	CITY/STATE Clearwater, FL 33756

III. The purpose or need for this disclosure is:

- Further Medical Care   
  Attorney   
  School   
  Research   
  Other (Specify) \_\_\_\_\_  
 Personal Use   
  Insurance   
  Disability   
  Health Information Exchange (IHS/Other \_\_\_\_\_ )

IV. The information to be disclosed from my health record: (check appropriate box(es))

- Only information related to (specify) \_\_\_\_\_  
 Only the period of events from \_\_\_\_\_ to \_\_\_\_\_  
 Other (specify) (CHS, Billing, etc.) \_\_\_\_\_  
 Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- Alcohol/Drug Abuse Treatment/Referral   
  HIV/AIDS-related Treatment  
 Sexually Transmitted Diseases   
  Mental Health (Other than Psychotherapy Notes)  
 Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years.

\_\_\_\_\_  
*(Specify new date)*

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is:  
 (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (State relationship to patient)	DATE
SIGNATURE OF WITNESS (If signature of patient is a thumbprint or mark)	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

<p><b>PATIENT IDENTIFICATION</b></p> <div style="border: 1px dashed black; height: 150px; width: 100%;"></div>	NAME (Last, First, MI)	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH